MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 16 1934

1. PLACE OF DEATH
County Ray
Township Polk
City Lawson Mo (No. ..... St. ..... Ward)
Registration District No. 742
Primary Registration District No. 5977a
File No. 26081
Registered No. 1

2. FULL NAME Judson Watkins
(a) Residence. No. Lawson Mo St. ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Margaret Watkins
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 24-1856

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	6	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): Clay Co
(STATE OR COUNTRY): Mo

PARENTS
10. NAME OF FATHER: Walters Watkins
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Ky
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Mary Halloway
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Ky
(STATE OR COUNTRY)

14. INFORMANT: Mrs Margaret Watkins
(Address) Lawson Mo

15. FILED July 21, 1934. Edwin Shouse, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 20 1934

17. I HEREBY CERTIFY, That I attended deceased from January 4, 1932, to July 20, 1934, that I last saw him alive on January 4, 1934, and that death occurred, on the date stated above, at 8:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Sclerosis of Arteries
Paralysis Followed with
Gangrene of Feet + Comp. and
Death
(duration) 2 yrs. 7 mos. ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Place of Death
DID AN OPERATION PRECEDE DEATH? No DATE OF. —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W G Estill, M. D
, 19 (Address) Lawson Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Lawson Cemetery — DATE OF BURIAL: 7-22 1934
20. UNDERTAKER: John C. Prather — ADDRESS: Excelsior Springs Mo

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*,

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *Measles: Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

#2

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

Ray

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Jeedson Watkins

Who died at _____ on July 20 - 1934

Residence: No. _____ St. _____

(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex M Color or race W ~~Single~~, married, ~~widowed or divorced~~: _____

Date of birth _____ Age: Years 77 Months 6 Days 26

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

_____ _____

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) Sclerosis of Arteries - Paralysis Hemiplegia followed by Pneumonia of Left - Lobar

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Pneumonia after 3 years of Sickness with Hemiplegia following the Cerebral Hemorrhage causing his death 6 20 34

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy?

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

_____

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

X Signature of Registrar X Edwin Shouse Date filed

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 742

Primary Reg. Dist. No. 5977a

Very truly yours,

E. T. McGaugh M.D.

Special Agent.

S-24081